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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **VINCENT TIU YU,** **aka VINCENT YU,** **aka VINCENT T. YU** **29897 30th Avenue South** **Federal Way, WA 98003** **Registered Nurse License No. 531910** Respondent.	Case No. 2013 - 728 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about April 25, 1997, the Board issued Registered Nurse License Number 531910 to Vincent Tiu Yu, also known as Vincent Yu and Vincent T. Yu ("Respondent"). Respondent's registered nurse license was in full force and effect at all times relevant to the charges brought herein and will expire on February 28, 2015, unless renewed.

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STATUTORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct . . .
>
> . . . .
>
> (4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action . . .
>
> " e) Making or giving any false statement or information in connection with the application for issuance of a certificate or license."

COST RECOVERY

6. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

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CAUSE FOR DISCIPLINE

(Disciplinary Action by the Washington Nursing Care Quality Assurance Commission)

7. Respondent' license is subject to disciplinary action pursuant to Code section 2761 (a)(4), on the grounds of unprofessional conduct because Respondent was disciplined by the Washington Nursing Care Quality Assurance Commission ("Washington Commission"). On or about June 6, 2012, pursuant to the Findings of Fact, Conclusions of Law, and Final Order in the disciplinary proceeding titled "In the Matter of: Vincent T. Yu", Master Case No. M2010-1356, the Washington Commission indefinitely suspended Respondent's credential to practice as a registered nurse in the state of Washington. The Washington Commission further ordered that prior to any request for reinstatement, Respondent shall undergo a complete psycho-sexual evaluation by a psychiatrist or mental health specialist who is credentialed by the state of Washington and pre-approved by the Commission, and provide an evaluative report to the Commission. A true and correct copy of the Findings of Fact, Conclusions of Law, and Final Order is attached as **exhibit A** and incorporated herein. The Washington Commission found that certain facts were established by clear and convincing evidence, presented at the hearing on April 26, 2012, including the following:

Patient B

a. Respondent began working as a registered nurse for Swedish Hospital - First Hill (Swedish) in July 2000, and has worked the swing shift (3:00 p.m. to 11:00 p.m.) for the last ten years in the orthopedic unit.

b. Patient B, a 53 year old male, was admitted to Swedish for spinal surgery on or about July 7, 2008. Patient B was transferred to Swedish's orthopedic unit on July 12, 2008.

c. On July 14, 2008, Respondent was working the swing shift as a registered nurse in the orthopedic unit at Swedish and was assigned to provide nursing care to Patient B.

d. On July 14, 2008, at approximately 7:30 p.m., Respondent entered Patient B's room and offered Patient B a leg massage. While performing the leg massage, Respondent placed Patient B's left foot in the center of his (Respondent's) groin and rubbed it up and down - moving

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it on his penis. As this occurred, Patient B could feel Respondent's erect penis. Respondent's conduct left Patient B feeling violated.

Patient A

e. Patient A, a 62 year old male, was admitted to Swedish for back surgery on or about January 13, 2010.

f. On January 16, 2010, Respondent was working the swing shift as a registered nurse on the orthopedic floor at Swedish. Patient A was a patient in the orthopedic unit on that day, but Respondent was not assigned to provide nursing care to him.

g. On January 16, 2010, Respondent entered Patient A's room and massaged Patient A's feet on two occasions. On both occasions, during the course of the massaging activity, Respondent pressed Patient A's left foot into his (Respondent's) groin area and requested that Patient A push his foot against Respondent's body. On at least one occasion, Patient A felt Respondent's erect penis with his toes. Respondent's actions left Patient A feeling uncomfortable and vulnerable. Patient A reported the incident to nurse manager L. C., and stated that he felt Respondent was pleasuring himself by placing Patient A's foot against his groin.

h. On January 25, 2010, Swedish terminated Respondent for a pattern of inappropriate behavior of a sexual nature with patients.

i. The Washington Commission found that Respondent had engaged in sexual misconduct or contact with vulnerable patients.

SECOND CAUSE FOR DISCIPLINE

(False Information In License Renewal)

8. Respondent's license is subject to disciplinary action pursuant to Code section 2761(e) on grounds that Respondent submitted false information under penalty of perjury on his renewal application.

9. Paragraph 7 is incorporated herein as though set forth at length. On or about December 10, 2012 Respondent signed and submitted a renewal application for California Registered Nursing License No. 531910. Respondent answered no under penalty of perjury to the question of "Since you last renewed your license, have you had a license disciplined by a

government agency or other disciplinary body; or have you been convicted of any crime in any state, the USA and its territories, military court or another country". Respondent's answer was false at the time the application was submitted for renewal of the California Registered Nursing License.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 531910, issued to Vincent Tiu Yu, also known as Vincent Yu and Vincent T. Yu;

2. Ordering Vincent Tiu Yu, also known as Vincent Yu and Vincent T. Yu, to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: MARCH 11, 2013

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SA2012107224

EXHIBIT A

Findings of Fact, Conclusions of Law, and Final Order

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
NURSING CARE QUALITY ASSURANCE COMMISSION

In the Matter of: VINCENT T. YU, Credential No. RN.RN.00126638, Respondent.	Master Case No. M2010-1356 FINDINGS OF FACT, CONCLUSIONS OF LAW, AND FINAL ORDER

APPEARANCES:

Respondent, Vincent T. Yu, by
Benjamin Nivlson, Attorney at Law

Department of Health Nursing Program (Department), by
Office of the Attorney General, per
Cassandra Buyserie, Assistant Attorney General

PANEL: Susan L. Woods, Ph.D., R.N.
Linda Batch, L.P.N.
William Hagens, Public Member

PRESIDING OFFICER: Debra Defreyn, Health Law Judge

A hearing was held in this matter on April 26, 2012, regarding allegations of unprofessional conduct. License suspended.

ISSUES

Did the Respondent commit unprofessional conduct as defined in RCW 18.130.180(1), (4), (7), and (24), and WAC 246-840-740(1) and (2)?

If the Department proves unprofessional conduct, what are the appropriate sanctions under RCW 18.130.160?

SUMMARY OF PROCEEDINGS

At the hearing, the Department presented the testimony of the following witnesses:

1. The Respondent;
2. Patient A;
3. Patient B; and
4. Lori Cross, R.N., Nurse Manager, Swedish Medical Center.

The Respondent testified on his own behalf.

The Presiding Officer admitted the following Department exhibits:

D-1: Complaint, dated January 29, 2010;

D-2: Patient A's Statement, dated March 10, 2010;

D-3: Swedish Medical Center Investigation Report, dated January 22, 2010, pages 4-7 and 10-11;

D-4: Statement of Lori Cross, R.N., dated June 7, 2010;

D-5: Statement of Alona Habinsky, R.N., dated June 27, 2010;

D-6: Statement of Bing Hui Chou, R.N., dated June 9, 2010;

D-7: Statement of Catherine Eldred, R.N., dated June 18, 2010;

D-8: Statement of Nancy Shamp, dated June 28, 2010;

D-9: Patient A's Medical Records provided by Swedish Medical Center;

D-10: Patient B's Statement;

D-11: Swedish Medical Center's Investigation;

D-12: Patient B's medical records provided by Swedish Medical Center;

D-13: Swedish Medical Center's Non-Discrimination and Non Harassment Human Resources Policy/Procedure; and

D-14: Respondent's Statement, dated July 1, 2010.

The Presiding Officer admitted the following Respondent exhibit:

R-19: Select copies of documents from Respondent's personnel file while employed at Swedish Medical Center.

I. FINDINGS OF FACT

The following findings of fact are established by clear and convincing evidence:

1.1 The Respondent is a Filipino male who immigrated to the United States in 1995. He became a citizen of the United States in 2000.

1.2 The Respondent became a registered nurse in the Philippines in 1994. After coming to the United States, the Respondent first worked as a certified nursing assistant. The state of Washington granted the Respondent a license to practice as a registered nurse on May 28, 1997.

1.3 The Respondent began working as a registered nurse for Swedish Hospital – First Hill (Swedish) in July 2000. He has worked the swing shift (3:00 p.m. to 11:00 p.m.) for the last ten years in the orthopedic unit.

Patient B

1.4 Patient B is a 53-year-old male who was admitted to Swedish for a spinal surgery on or about July 7, 2008. Patient B was transferred to Swedish's orthopedic unit on July 12, 2008.

1.5 On July 14, 2008, the Respondent was working the swing shift as a registered nurse in the orthopedic unit at Swedish and was assigned to provide nursing care Patient B.

1.6 On July 14, 2008, at approximately 7:30 pm., the Respondent entered Patient B's room and offered Patient B a leg massage. While performing the leg massage, the Respondent placed Patient B's left foot in the center of his (the Respondent's) groin and rubbed it up and down – moving it on his penis. As this occurred, Patient B could feel the Respondent's erect penis. In response to the Respondent's actions, Patient B informed the Respondent that he "didn't like men" and "was engaged."

1.7 The Respondent's conduct left Patient B feeling violated.

1.8 On July 15, 2008, at 12:40 a.m., Patient B called his assigned nurse and asked that she bring a witness with her to his room. When they were both present, Patient B told Nena Acido, R.N., and Jackie Fore, L.P.N., that he was sexually molested earlier that evening by a "short Filipino guy" who "rubbed his private parts on his legs." After reporting the incident to the nurses, Patient B called his father and told him what had happened. Patient B also reported the Respondent's conduct to his treating physician, Dr. Jay Williams, when Dr. Williams came to his room later that morning.

1.9 On July 15, 2008, Lori Cross, the Respondent's nurse manager at Swedish, interviewed Patient B about his report of the Respondent's conduct. Patient B informed her that the Respondent "started rubbing himself with (Patient B's) foot." Patient B informed Ms. Cross that he was reporting the incident to protect other people.

1.10 Following his report of the Respondent's conduct, it was determined by Swedish medical staff, including a psychiatrist, that Patient B was psychotic. Ms. Cross took Patient B's subsequent mental health diagnosis into account when she found no reason to discipline the Respondent for the conduct Patient B alleged took place.

Patient A

1.11 Patient A is a 62-year-old male who was admitted to Swedish for back surgery on or about January 13, 2010.

1.12 On January 16, 2010, the Respondent was working the swing shift as a registered nurse on the orthopedic floor at Swedish. Patient A was a patient in the orthopedic unit on that day, but the Respondent was not assigned to provide nursing care to him.

1.13 On January 16, 2010, the Respondent entered Patient A's room and massaged Patient A's feet on two occasions. On both occasions, during the course of the massaging activity, the Respondent pressed Patient A's left foot into the Respondent's groin area and requested that Patient A push his foot against the Respondent's body. On at least one occasion, Patient A felt the Respondent's erect penis with his toes.

1.14 The Respondent's actions left Patient A feeling uncomfortable and vulnerable. The next morning, Patient A reported the Respondent's conduct to his wife and his assigned nurse in order to prevent the Respondent's conduct from happening to someone else. The assigned nurse reported the incident to the nurse manager.

1.15 Lori Cross interviewed Patient A on January 18, 2010 and on January 20, 2010. In both interviews, Patient A recounted that the Respondent put Patient A's left foot against the Respondent's groin area and told Patient A to push his foot against the Respondent's body. Patient A reported to Ms. Cross that he felt the Respondent was pleasuring himself by placing Patient A's foot against his groin.

1.16 On January 25, 2010, Swedish terminated the Respondent for a pattern of inappropriate behavior of a sexual nature with patients.

Credibility Findings

1.17 The panel finds Patients A and B more credible than the Respondent. Both patients reported similar conduct by the Respondent. Neither patient knew the Respondent prior to his nursing care of them nor had any antagonism toward him. Neither patient knew the other nor had any motive or reason to lie about the Respondent's conduct. Both patients reported the Respondent's conduct at the time of the events in order to protect other patients.

1.18 Patient A's testimony was delivered in a calm, straightfonward manner. He was forthright regarding his ability or inability to recall the events of January 16, 2010, and candid about his perceptions of those events, as well as his reason for reporting the Respondent's conduct.

1.19 Patient B testified in a fixed manner, with a military bearing, but with genuineness and sincerity.

1.20 The Respondent testified that he did touch Patient A's and Patient B's feet while providing nursing care to them, but that the touching was during the course of

performing dorsiflexion exercises[1] with his palm. The Respondent denies having placed Patient A's or Patient B's foot against his body or against his groin in any manner. He likewise denies having placed either patient's foot on his penis.

1.21 It is highly probable that the Respondent, knowing that both Patient A and Patient B were receiving narcotic medication that had a tendency to make them groggy or sleepy, and knowing both patients had limited mobility due to having recently had back surgery, took advantage of the opportunities and had physical contact with the patients for his own sexual gratification.

II. CONCLUSIONS OF LAW

2.1 The Commission has jurisdiction over the Respondent and subject of this proceeding. RCW 18.130.040 RCW.

2.2 The Commission used its experience, competency, and specialized knowledge to evaluate the evidence. RCW 34.05.461(5).

2.3 Except as otherwise required by law, the Department bears the burden of proving the allegations set forth in the Statement of Charges by a preponderance of the evidence. WAC 246-11-520. The Washington Supreme Court has held the standard of proof in disciplinary proceedings against physicians is proof by clear and convincing evidence. *Nguyen v. Department of Health*, 144 Wn.2d 516, 534 (2001), cert. denied, 535 U.S. 904 (2002). In 2006, the Washington Supreme Court extended the *Nguyen*

[1] On a supine patient, a proper dorsi-flexion/plantar-flexion exercise is performed by the nurse cradling the foot or holding the foot with both hands and pushing the toes away from the body and then pulling the toes toward the body (and vice versa). It does not involve resting, pushing, or placing the foot on the nurse's body.

holding to all professional disciplinary proceedings. *Ongom v. Dept. of Health*, 159 Wn.2d 132 (2006), cert. denied 550 U.S. 905 (2007). However, in 2011, the Washington Supreme Court overruled *Ongom*, but declined to overrule *Nguyen*. *Hardee v. Dept. of Social and Health Services*, 172 Wn.2d 1 (2011).

2.4 Any legal uncertainty regarding the standard of proof is immaterial in this case as the Commission made its findings under the clear and convincing standard.

2.5 The Department proved by clear and convincing evidence that the Respondent violated RCW 18.130.180(1), which states that the following conduct, acts or conditions constitute unprofessional conduct:

> The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not.

2.6 An act of moral turpitude is one which violates commonly accepted standards of good morals, honesty, or justice. *In re Hopkins*, 54 Wn. App. 569 (1909). To relate to the practice of the profession under RCW 18.139.180(1) "the conduct must indicate unfitness to bear the responsibilities of, and enjoy the privileges of, the profession." *Haley v. Medical Disciplinary Board*, 117 Wn.2d 720, 731 (1991). Conduct may indicate unfitness to practice the profession if: 1) it raises reasonable concerns that the individual may abuse the status of the profession to harm members of the public, or 2) it lowers the standing of the profession in the eyes of the public. *Haley*, 117 Wn.2d at 733.

2.7 The Respondent had sexual contact with vulnerable patients. This conduct both raises reasonable concerns for the safety of patients under the Respondent's care and lowers the standing of the profession in the eyes of the public.

2.8 The Department proved by clear and convincing evidence that the Respondent violated RCW 18.130.180(4), which states that the following conduct, acts or conditions constitute unprofessional conduct:

> Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed.

2.9 The Department proved by clear and convincing evidence that the Respondent violated RCW 18.130.180(7), which states that the following conduct, acts or conditions constitute unprofessional conduct:

> Violation of any state or federal statute or administrative rule regulating the profession in question, including any statute or rule defining or establishing standards of patient care of professional conduct or practice.

2.10 WAC 246-840-740 states:

> (1) What is the nursing commission's intent in prohibiting this type of misconduct?
>
> Sexual or romantic conduct with a client or the client's family is serious misconduct because it harms the nurse/client relationship and interferes with the safe and effective delivery of nursing services. A nurse or nursing technician does not need to be "assigned" to the client in order for the nurse/client relationship to exist. The role of the nurse or nursing technician in the nurse/client relationship places the nurse or nursing technician in the more powerful position and the nurse or nursing technician must not abuse this power. Under certain circumstances, the nurse/client relationship continues beyond the termination of nursing services. Not only does sexual or romantic misconduct violate the trust and confidence held by health care clients towards nursing staff, but it also

undermines public confidence in nursing. Nurses and nursing technicians can take measures to avoid allegations of such misconduct by establishing and maintaining professional boundaries in dealing with their clients.

(2) What conduct is prohibited?

Nurses and nursing technicians shall never engage, or attempt to engage, in sexual or romantic conduct with clients, or a client's immediate family members or significant others. Such conduct does not have to involve sexual contact. It includes behaviors or expressions of a sexual or intimately romantic nature. Sexual or romantic conduct is prohibited whether or not the client, family member or significant other initiates or consents to the conduct. Such conduct is also prohibited between a nursing educator and student.

2.11 The Department proved by clear and convincing evidence that the Respondent violated RCW 18.130.180(24), which states that the following conduct, acts or conditions constitute unprofessional conduct: Abuse of a client or patient or sexual contact with a client or patient.

2.12 In determining appropriate sanctions, public safety must be considered before the rehabilitation of the Respondent. RCW 18.130.160. The Respondent's conduct falls under Tier B of the Sexual misconduct or contact schedule. WAC 246-16-840.

2.13 The starting point for the duration of sanctions is the middle of the tier range. The range associated with Tier B of the Sexual Misconduct or Contact sanction schedule is 2 – 5 years; however, this range does not adequately address the facts of this case. Rather, the panel believes the public will be better protected with a sanction that prevents the Respondent from working as a registered nurse until a professional evaluator finds the Respondent poses no further risk to patients.

III. ORDER

3.1 The Respondent's license to practice as a registered nurse in the state of Washington is INDEFINITELY SUSPENDED.

3.2 Prior to any request for reinstatement, the Respondent shall undergo a complete psycho-sexual evaluation by a psychiatrist or mental health specialist who is credentialed by the state of Washington and pre-approved by the Commission and provide an evaluative report to the Commission. The evaluation must be completed within 90 days of any reinstatement request. The Respondent shall provide the evaluator with a copy of this Final Order and any releases for information that the evaluator might request. The evaluator shall conduct a complete psycho-sexual evaluation and prepare a report. The Respondent shall assure that the evaluator provides the Commission with a copy of the evaluation report and all raw data that support the evaluator's findings. The report shall include:

i. A description of the evaluation process and the Respondent's cooperation with that process;

ii. The evaluator's opinion on whether Respondent can practice as a registered nurse without posing an unreasonable risk of harm to the patients or the public and a statement of all factual basis for that opinion;

iii. If the evaluator opines that Respondent cannot practice without posing an unreasonable risk of harm, the evaluator's recommendations, if any, for mental health counseling or other treatment the evaluator believes Respondent should undergo so that he might safely practice at a later date; and

iv. If the evaluator believes that the Respondent can safely practice, a detailed description of any and all practice conditions and restrictions the evaluator recommends imposing, if any. Among other considerations, the evaluator shall determine whether

Respondent should undergo ongoing mental health counseling as a condition of practice.

3.3 Prior to reinstatement, the Respondent must also demonstrate that he meets relevant regulatory requirements for a registered nurse credential.

3.4 Change of Address. The Respondent shall inform the Commission and the Adjudicative Service Unit, in writing, of changes in his residential and/or business address within 30 days of such change.

3.5 Assume Compliance Costs. The Respondent shall assume all costs of complying with all requirements, terms, and conditions of this order.

Dated this 6th day of June, 2012.

Susan L Woods

SUSAN L. WOODS, Ph.D., R.N.
Panel Chair

CLERK'S SUMMARY

Charge	Action
RCW 18.130.180(1)	Violated
RCW 18.130.180(4)	Violated
RCW 18.130.180(7)	Violated
RCW 18.130.180(24)	Violated
WAC 246-840-740	Violated

NOTICE TO PARTIES

This order is subject to the reporting requirements of RCW 18.130.110, Section 1128E of the Social Security Act, and any other applicable interstate or national reporting requirements. If discipline is taken, it must be reported to the Healthcare Integrity Protection Data Bank.

Either party may file a **petition for reconsideration**. RCW 34.05.461(3); 34.05.470. The petifion must be filed within 10 days of service of this order wlth:

Adjudicative Service Unit
P.O. Box 47879
Olympia, WA 98504-7879

and a copy must be sent to:

Department of Health Nursing Program
P.O. Box 47864
Olympia, WA 98504-7864

The petitlon must state the specific grounds for reconsideration and what relief is requested. WAC 246-11-580. The petition is denied if the Commission does not respond in writing within 20 days of the filing of the petition.

A **petition for judicial review** must be filed and served within 30 days after service of this order. RCW 34.05.542. The procedures are identified in chapter 34.05 RCW, Part V, Judicial Review and Civil Enforcement. A petition for reconsideration is not required before seeking judicial review. If a petition for reconsideration is filed, the above 30-day period does not start until the petition is resolved. RCW 34.05.470(3).

The order is in effect while a petition for reconsideration or review is filed. "Filing" means actual receipt of the document by the Adjudicative Service Unit. RCW 34.05.010(6). This order is "served" the day it is deposited in the United States mail. RCW 34.05.010(19).

For more information, visit our website at http://www.doh.wa.gov/hearings.